2011		HMO-1	POS-C	
Health Insurance				
Comparison Chart		**2008 monthly cap $95 for health/dental/vision premium contribution**	**2008 monthly cap $160 for health/dental/vision premium contribution**	
Local 603 only		6% prem contribution (2008 prem contr rate)	9% prem contribution (2008 prem contributate rate)	
@ 2008 premium	Single	$31.41	$53.94	
contribution levels	Employee/Child	$57.90	$99.40	
(successor contracts	Employee/Spouse	$65.97	$113.27	
not settled)	Family	~~$101.63~~ **$87.58**	~~$174.48~~ **$148.86**	
			In-Plan	Out-of-Plan
	Co-Pays	as listed below	as listed below	
	Annual Deductibles	n/a		$300 individual/ $600 family
	Co-Insurance	n/a		20% of eligible expenses, unless otherwise specified
	Annual Out-of-Pocket Limit	n/a		$700 individual/ $1400 family
				Coverage for Out-of-Network services which require Prior Authorization as listed in the Point of Service Plan Rider will have a 50% benefit reduction up to a max of $500/occurrence if the services are not Prior Authorized.

This comparison chart is not a guarantee of coverage, please refer to the Certificate of Coverage, and Riders for detailed benefit information restrictions, limitations and exclusions that apply to that coverage.

		HMO-1 Local 603	POS-C Local 603	
Services			In-Plan	Out-of-Plan
Wellness/ Preventive Health	• Well Child Care Exams	No Charge	No Charge	Deductible/Co-insurance
	• Periodic Physical Exams	No Charge	No Charge	Deductible/Co-insurance
	• Immunizations	No Charge	No Charge	Deductible/Co-insurance
	• Routine Mammography Services	No Charge	No Charge	Deductible/Co-insurance

Date: December 4, 2008

This comparison chart is not a guarantee of coverage, please refer to the Certificate of Coverage, and Riders for detailed benefit information restrictions, limitations and exclusions that apply to that coverage.				
		HMO-1 Local 603	**POS-C Local 603**	
Services			In-Plan	Out-of-Plan
Physician and Practitioner Services	**Primary Care Practitioner**			
	• Office and Home visits	$10 Co-pay per visit	$15 Co-pay per visit	Deductible/Co-insurance
	• Inpatient visits	No Charge	No Charge	Deductible/Co-insurance
	Specialty Physician			
	• Office and Home visits	$10 Co-pay per visit	$15 Co-pay per visit	Deductible/Co-insurance
	• Routine Eye Exams *(limited to one per 12-month period)*	$10 Co-pay per visit	$15 Co-pay per visit	Deductible/Co-insurance
	• Chiropractic office visits and manipulations	$10 Co-pay per visit	$15 Co-pay per visit	Deductible/Co-insurance
	• Allergy Immunizations	No Charge	No Charge	Deductible/Co-insurance
	• Accidental Dental Services	No Charge	No Charge	No Charge
	• Radiation/Chemotherapy Services	No Charge	No Charge	Deductible/Co-insurance
	• Dialysis Services	No Charge	No Charge	Deductible/Co-insurance
	• Surgery & Anesthesiology Services	No Charge	No Charge	Deductible/Co-insurance
	• Routine Maternity (pre & post natal care)	No Charge	No Charge	Deductible/Co-insurance
	• Inpatient visits	No Charge	No Charge	Deductible/Co-insurance
	• Injectables administered in a Physician's office	*Please refer to your Prescription drug benefit levels*	*Please refer to your Prescription drug benefit levels*	*Please refer to your Prescription drug benefit levels*
Diagnostic Services	• X-Ray, Lab, Pathology *(practitioner's office or outpatient)*	No Charge	No Charge	Deductible/Co-insurance
	• Diagnostic Mammography Services	No Charge	No Charge	Deductible/Co-insurance
	• PET Scans, MRI's, MRA's, CT Scans *(no coverage if not prior authorized)*	No Charge	No Charge	Deductible/Co-insurance
	• Stress Tests	No Charge	No Charge	Deductible/Co-insurance
	• Ultrasounds/Echocardiograms	No Charge	No Charge	Deductible/Co-insurance
Hospital Services	• Inpatient Hospital *(no coverage if not prior authorized)*	No Charge	Deductible/Co-insurance	Deductible/Co-insurance
	• Outpatient Services or Procedures *(including cardiac rehabilitation)*	No Charge	Deductible/Co-insurance	Deductible/Co-insurance

This comparison chart is not a guarantee of coverage, please refer to the Certificate of Coverage, and Riders for detailed benefit information restrictions, limitations and exclusions that apply to that coverage.				
		HMO-1 Local 603	**POS-C Local 603**	
Services			In-Plan	Out-of-Plan
Hospital Services (cont'd)	• Ambulatory Surgical Center *(such as a colonoscopy)*	No Charge	Deductible/Co-insurance	Deductible/Co-insurance
Rehabilitation Services	• Therapy – Physical/Occupational/Speech	$10 Co-pay per visit	$15 Co-pay per visit	Deductible/Co-insurance
Ambulance Services	• Land and Air	No Charge	No Charge	No Charge
Home Health Care	• Limited to 40 visits per 12-month period *(no coverage if not prior authorized)*	No Charge	No Charge	Deductible/Co-insurance
Hospice Care	*No Coverage if not prior authorized*	No Charge	No Charge	Deductible/Co-insurance
Durable Medical Equipment	• DME, Orthotics & Prosthetics *(Prior authorization required for Durable Medical Equipment/Orthotics over $500 and prothetics over $1,000. No coverage if not prior authorized.)*	No Charge	Deductible/Co-insurance	Deductible/Co-insurance
Diabetic Supplies	*(Please refer to your Prescription Summary of Member Responsibility Table)*			
Medical Supplies	Including insulin pump supplies	No Charge	No Charge	Deductible/Co-insurance
Health Educational Programs	*Please refer to the Certificate of Coverage for a list of benefits and limitations.*	No Charge	No Charge	Not covered
Behavioral Health	Mental Health and Chemical Dependency Services • Inpatient – Limited to 10 days per calendar year *(no coverage if not prior authorized)* • Transitional – Limited to 20 days per calendar year • Outpatient – Limited to 20 visits per calendar year	No Charge No Charge No Charge	No Charge No Charge No Charge	Deductible/Co-insurance Deductible/Co-insurance Deductible/Co-insurance

This comparison chart is not a guarantee of coverage, please refer to the Certificate of Coverage, and Riders for detailed benefit information restrictions, limitations and exclusions that apply to that coverage.				
		HMO-1 Local 603	**POS-C Local 603**	
Services			In-Plan	Out-of-Plan
Emergency/Urgent Care *(Emergency room or hospital based urgent care facility)*	• Emergency Room Services *(co-pay waived if admitted inpatient within 24 hours)*	$50 Co-pay per visit	$50 co-pay per visit	$50 co-pay per visit
	• Urgent Care	$10 Co-pay per visit	$15 Co-pay per visit	Deductible/Co-insurance
Maximum Policy Benefit		$5,000,000 per Member per Lifetime	$5,000,000 per Member per Lifetime	
Prescription		Retail Pharmacy: $10/25/50/50/80 co-pay Mail Order Pharmacy: $25/60/150 co-pay	Retail Pharmacy: $10/25/50/50/80 co-pay Mail Order Pharmacy: $25/60/150 co-pay	